FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING TN1911 04/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2733 MCCAMPBELL AVENUE **DONELSON PLACE CARE & REHABILITATION** NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 002 1200-8-6 No Deficiencies N 002 No deficiencies were cited as a result of complaint investigation TN00029542 completed on 4/4/12.

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE